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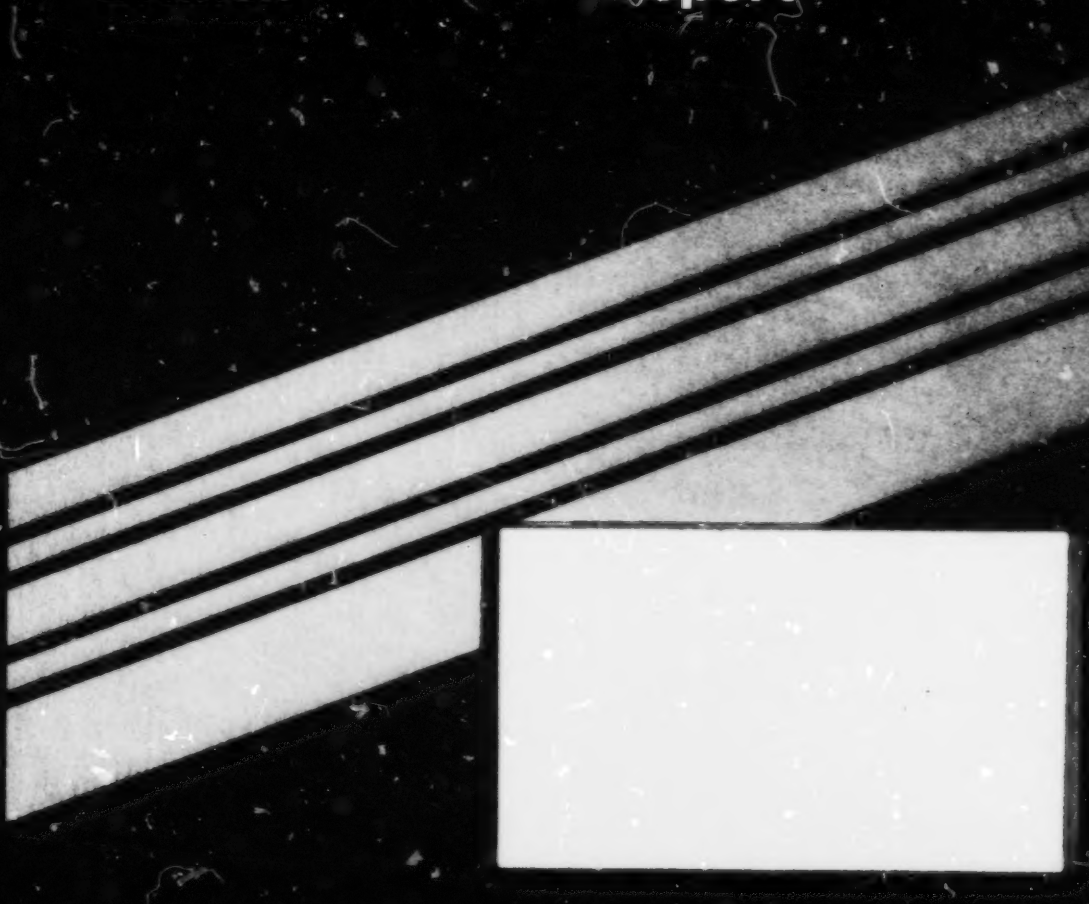

J. Stephen Wormith
Senior Research Officer

Mark Borzecki
Psychology Department
University of Ottawa

A SURVEY OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS IN CANADA

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INTRODUCTION

In its annual priority setting exercise, the Research Division of the Ministry of the Solicitor General has repeatedly acknowledged the unique problems and concerns related to groups of 'special offenders', specifically women, native, and sexual offenders. As part of the research initiative on sexual offenders, a survey of treatment regimens offered by state corrections and related mental health agencies in the United States was undertaken in 1983. The results of this study were reported in a previous Programs Branch User Report (Borzecki and Wormith, 1984). In that report, a wide range of services was noted among the 22 programs in the survey. Program variation was ascribed to differences in target population, the therapeutic orientation of program organizers, and the availability of resources. A paucity of evaluation and follow-up data was observed. Suggestions that were put forth in view of the material submitted included the use of a multimodal assessment, techniques for maximizing the utility of scarce resources, and various types of therapeutic services. The following report represents an extension of the original exercise to a survey of Canadian services.

METHOD

In late 1984, letters and phone calls went out to the administrators of the provincial correctional departments and to the various mental health centres with which the authors were familiar. Information was requested concerning any treatment program to which sexual offenders could be referred for their antisocial sexual behaviour. Documentation pertaining to research carried out with this specific offender population was also requested.

As was the case with the American survey, the nature and method of response differed tremendously. As a result, a varied body of literature was amassed. Material included formal papers, brochures of program description, phone conversations, internal documents, memorandum and letters. Published Canadian articles on sex offender programs were also considered, however most of these reports tended to be either dated (Freund, Seely & Marshall, 1972; Hartman, 1961; Silverman, 1971; Turner, 1961), experimental studies of specific behavioural (Marshall & Barbaree, 1978; Marshall, 1979; Quinsey, Bergersen & Steinman, 1976; Quinsey, Chaplin & Carrigan, 1980) and pharmacological procedures (Gagne, 1981), or general review papers (Quinsey, 1977, 1984; Quinsey & Marshall, 1983).

Only a few notable studies addressed the evaluation of comprehensive sex offender programs (Marshall, 1973; Marshall & Quinsey, 1983; McKnight, 1975). Other reports evaluated the impact of a complete treatment component, such as social still training (whitman and Quinsey, 1981) and therefore were included in the review. The survey also revealed that other centres, well known for their work in the field of sexual deviation, such as the Clarke Institution of Psychiatry in Toronto, specialize in assessment or related research, but at the time of the polling, did not have an active treatment program as per our operationalized criteria.

In order to analyze the diverse collection of material in a systematic manner, a standard form was designed so that relevant aspects of the different programs could be captured. A copy of the evaluation form is appended (Appendix A).

It should be noted that the initial polling included centres operated under the auspices of mental health services, as well as federal (Correctional Service of Canada) and provincial corrections. As such, the present report constitutes a reasonably comprehensive survey of services available within Canada. The following descriptive information may, therefore, be considered representative of programs and treatment activities for sexual offenders in Canada.

It is not implied, however, that the survey is an exhaustive review of Canadian programs. In particular, we suspect that services for the 'less severe' sexual offenders (those receiving noncarceral sentences or those who are diverted from formal criminal justice agencies) were more likely to have been overlooked.

RESULTS

The characteristics of treatment activities for sexual offenders are described under ten separate program dimensions. A description of these treatment characteristics is presented below and is summarized in a series of tables.

Response Rates and Program Criteria

All provinces and territories were contacted. However, only 6 of the 10 provinces reported an established sex offender program, or one that was in the latter stages of planning. A "formal" program was defined as one in which services are available on a province-wide basis and are geared specifically toward sex offenders. Nonspecific therapy, whereby sex offenders received the same services as regular inmates or patients as part of a prison or mental health program, did not qualify as a formal sex offender program. For example, the psychology program at Stony Mountain Institution (CSC) in Manitoba includes a regimen of individual psychotherapy in which about 6 sex offenders are participating at any one time (Chaudry, 1985). However, this service is not included in the present study since it is not a "sex offender program" per se.

Furthermore, the dynamic aspect of program evolution must be acknowledged. The provision of services varies over time as personnel changes and techniques improve. Some of the submitted

information was current while other reports were clearly dated. Every attempt was made to describe each program in terms of its current status, although major historic changes were also recorded.

It is noted that one program in development, found at Dorchester Penitentiary in New Brunswick has been proposed to serve the Atlantic region of C.S.C. Elsewhere, a short term program for Mountain Institution (C.S.C.) to compliment existing services at the Region Psychiatric Centre (Abbotsford) awaits final approval at the time of writing. In addition, the Yukon and Northwest territories refer sex offenders assessed in need of treatment to neighbouring provincial programs (Saidman, 1985).

Year of Implementation

Reported implementation dates are listed in Table 1. Ontario was the first to introduce sex offender treatment, this being in 1972 at the Oak Ridge Mental Health Centre in Penetanguishene. The remaining programs were inaugurated throughout the 1970's and early 1980's. Hence, the specific treatment of sex offenders is a relatively recent undertaking in Canada.

Characteristics of Sex Offender Treatment Programs, Presented by Individual Province and City.

Table 1

Province (City)[a]	Year Implemented	Participating Agencies	Target Population[b,c]
Alberta, Calgary	1978	provincial health & corrections	nonviolent, no outstanding charges
Alberta, Edmonton	1981	provincial health, federal corrections	all sex offenders; motivated to change
B.C., Abbotsford	1973	provincial health, federal corrections	all sex offenders; motivated to change
B.C., Campbell River	1983	municipal health and police	nonviolent, nonhabitual; motivated to change
B.C., Vancouver	1979	provincial health	nonviolent, nonhabitual; motivated to change
Ontario, Brampton	1979	provincial health & corrections	all sex offenders; motivated to change
Ontario, Kingston	1974	federal corrections	offenders with sexually motivated crimes
Ontario, Ottawa	1983	provincial health, corrections	all sex offenders
Ontario, Penetanguishene	1972	provincial health	all sex offenders
Québec, Montréal	not stated	provincial health, federal corrections	all sex offenders; motivated to change
Saskatchewan, Prince Albert	1979	federal corrections	all sex offenders
Saskatchewan, Saskatoon	1978	provincial health, federal corrections	all sex offenders; motivated to change

Table 1, continued

Notes. [a]Alberta, Calgary - Calgary General Hospital, Sexual Deviation Clinic.
Alberta, Edmonton - Alberta Hospital Edmonton, Forensic Services Unit.
B.C., Abbotsford - Regional Psychiatric Centre, Pacific Region.
B.C., Campbell River - Campbell River Sex Offender Program (community based).
B.C., Vancouver - University of British Columbia Medical Centre, Sex Offender Treatment Program.
Ontario, Brampton - St. Thomas Psychiatric Hospital.
Ontario, Kingston - Regional Treatment Centre.
Ontario, Ottawa - Royal Ottawa Hospital, Sexual Behaviours Clinic.
Ontario, Penetanguishene - Oak Ridge Mental Health Centre.
Saskatchewan, Prince Albert - Saskatchewan Penitentiary.
Saskatchewan, Saskatoon - Regional Psychiatric Centre, Prairie Region, Clearwater Unit.
Québec, Montréal - Institut Philippe Pinel, McGill Forensic Clinic, Douglas Hospital.

[b]Although not specific target clientele, the following treatment centres will accept, in limited numbers, sex offenders who are psychiatrically disturbed (independent of any paraphilias):
Alberta Hospital Edmonton
St. Thomas Psychiatric Hospital
Kingston Regional Treatment Centre
Oak Ridge Mental Health Centre (if sufficient verbal skills)
Regional Psychiatric Centre, Saskatoon (if sufficient verbal skills)

[c]Programs in the developmental stage are found at Dorchester Penitentiary, New Brunswick, and Mountain Institution, B.C.
Manitoba (Stony Mountain Institution) provides services psychological but these are not specifically geared toward sex offenders.
The Yukon and Northwest Territories refer sex offenders assessed in need of treatment to neighbouring provincial programs.

Target Population

As shown in Table 1, there is some consistency with regard to the offender subgroups accepted for treatment. Nine of twelve programs will consider all sex offenders and three will accept nonviolent, nonhabitual sex offenders. Programs accepting only nonviolent offenders are those that provide outpatient-intensive services. All of the programs stressed that they admit only those offenders showing motivation to change.

Several of the programs will admit offenders with histories of psychiatric disorders. In fact, our data indicate that proportionately more programs accept this subgroup in Canada than in the United States. In some cases, the participants will be under a Warrant of the Lieutenant Governor or more rarely, will be institutionalized under provisions of the respective provincial mental health acts. However, only a limited number of placements are made available for these individuals since the additional psychiatric attention that they require can detract from the amount of service provided to other sex offenders. For those programs not accepting the psychiatrically disordered offender, a prevalent opinion is that the commission of the sex offense was only one manifestation of a deeper psychiatric/psychological problem that is more adequately dealt with in other ways.

Referral

Eleven of the twelve centres described their means of referral (Table 2). As was the case in the United States, the most common referral method was through the judiciary. Upon violation of sexual offense statutes, pending their previous record, offenders may be required by court to undergo screening by a program's clincial staff. However, contrary to the American practice, an individual may be required to undergo treatment, but still serve a regular prison sentence. It is also common practice in Canada to have probation and parole eligibility influenced by program participation and progress.

Program admittance rarely coincides wiht the commencement of sentence. Typically, program directors attempt to have a participant's anticipated parole date coincide with program completion so that he will not be released back into a prison milieu.

Ten of the eleven centres reporting their referral sources do take voluntary referrals, pending approval by the selection committee. Several of the hospital-based programs (e.g., Calgary General Hospital, Royal Ottawa Hospital) will even accept voluntary referrals from the community for those individuals who perceive a sexual deviation and consider themselves at risk to offend. It is noted that of the American programs, less than one third accept voluntary referrals.

The selection process is said to be rigorous in order to screen out those offenders wishing to "burn time" through therapy participation, with no real inclination toward prosocial change. However, a major problem with this kind of voluntary referral is that many offenders who are in need of services, but are poorly motivated, will elect to bypass treatment opportunities. The problem is also encountered in nonvoluntary referrals where clinical staff select only those offenders whom they feel are "treatable" or "motivated to change". However, with the limited bedspace and funding, there is a strong and understandable inclination toward accepting just such clientele.

To summarize, being convicted of a sex offense does not guarantee participation in a sex offender treatment program. The data provided indicate that in general, risk is not a big priority in admittance, contrary to the American practice. This finding is consistent with data presented elsewhere (Wormith, 1983) suggesting that individual motivation is given considerable weight in the selection of sexual offenders for existing programs in Canada.

Assessment

Potential participants for all of the cited programs are screened by clinical staff, either prior to admittance or during the orientation phase of the regimen.

Table 2

Province (City)	Referral Sources	Assessments
Alberta, Calgary	voluntary	psychometric, plethysmograph, neuropsychological, social skills
Alberta, Edmonton	court and voluntary	psychiatric, social-legal history, psychometric, plethysmograph, hormone profile, some EEG and CAT scanning
B.C., Abbotsford	institutional psychologists (other), and voluntary	psychiatric, social history, psychometric, behavioural assessment ("situational testing evaluations"), plethysmograph
B.C., Campbell R.	voluntary, parole and probation boards	not stated
B.C., Vancouver	court, probation & parole boards	legal, medical, psychometric, plethysmograph
Ontario, Brampton	court, institutional (other), voluntary	legal, sexual history, psychometric, plethysmograph
Ontario, Kingston	court, institutional (other), voluntary	legal, psychiatric, psychometric, plethysmograph
Ontario, Ottawa	court, parole and probation boards, voluntary	psychiatric, medical, psychometric, hormone profile, plethysmograph
Ontario, Penetanguishene	federal and provincial court	legal, psychiatric, behavioural assessment (for social skills), plethysmograph
Québec, Montréal	court, probation and parole boards, voluntary	legal, medical, psychiatric, psychometric, hormone profile, plethysmograph
Saskatchewan, Prince Albert	not stated	not stated
Saskatchewan, Saskatoon	court, institutional (other), voluntary	psychiatric, social history, psychometric, behavioural assessment (of heterosocial skills), plethysmograph

Inspection of Table 2 reveals that there is consensus among centres regarding methods of assessment. The procedure appears to be more elaborate than that found in the United States, and generally comprises: social history documentation (including legal record), psychiatric interview, a psychometric battery, plethysmographic assessment of deviant and nondeviant sexual arousal, and in some cases, behavioral assessment of heterosocial skills, and endocrinal analysis. Few programs provided a detailed list of psychological tests administered, but tests noted were the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), and the Derogatis Sexual Functioning Inventory (DSFI).

The proportionately greater use of plethysmography and hormone profiling reflects the greater use of behaviour modification techniques and antiandrogen treatment (using medroxyprogesterone acetate), respectively, in Canada. Moreover, the extensive use of behavioural assessments appears to be characteristic of Canadian programs. This is likely attributable to the behavioural orientation to which most Canadian treatment centres subscribe and to Canada's strong research history in the development of these techniques (Earls & Marshall, 1983; Freund, 1963; Langevin, 1983; Marshall and Barbaree, 1978; Quinsey, 1977). Similiarly, but to a lesser degree, the popularity of pharmacological approaches to assessment and treatment has a foundation in clinical research in Canada (Bradford, 1983; Bradford & McLean, 1984; Gagné, 1981).

Capacity and Staffing

Capacity and staffing characteristics of the programs are presented in Table 3. In absolute terms, capacity ranged from 4 (Pentanguishene, Ontario) to 38 (Alberta Hospital Edmonton). In all, enrollment was not as varied as in the United States. In Canada, the average capacity is approximately 25. This is likely attributable to the fact that most treatment of Canadian sex offenders is conducted on hospital wards (forensic hospitals or forensic wards) and not in prison treatment areas as it is typically done in the U.S. In addition, the relationship observed between program capacity and volunteerism in the U.S. was not found for Canada (Borzecki and Wormith, 1984).

Since program capacity was not particularly varied, it is not surprising that staffing was also consistent, in terms of numbers and personel type. Generally, there was at least one psychiatrist, one clinical psychologist, and one psychiatric nurse on clinical staff. In some cases, social workers were also used. Typically, psychiatrists would be employed on a half-time consulting basis, whereas clinical psychologists would be on staff full-time. No programs used volunteers. At Fort Steilacoom, Washington, use was made of "therapeutic supervisors" -- inmates who were in the latter stages of therapy and were verbally skilled. The RPC in Abbotsford uses a variant on this

approach, as does Oak Ridge at Penetanguishene, whereby all program newcomers were assigned a "buddy" who is another sex offender in the latter stages of the program.

Client-to-professional therapist ratios varied according to the treatment modality. Those in behavioral conditioning would undergo therapy on a one-to-one basis. Group psychotherapy sessions involved approximately 6 inmates to one therapist. Heterosocial skills training sessions typically made use of one male and one female therapist for approximately 8 inmates. These therapist-to-client ratios are decidedly more favourable than those found in the U.S. programs. However, the hospital-based nature of treatment in Canada likely accounts for this.

Treatment Duration and Intensity

A great deal of variability was found concerning duration and intensity of treatment (Table 3). However, with exceptions duly noted, this lack of consensus can be attributed to whether programs were resident or outpatient based. The outpatient and community programs delivered 2 to 3 hours of therapy per week. This is sensible given the fact that these programs are for low-risk clientele. In the resident programs, clients receive as much as 25 hours per week of therapy. Within programs, trends in treatment intensity were difficult to establish since half of the respondents stated nothing or noted that intensity depended on the individual client's program.

Table 3

Province (City)	Capacity	Staffing	Duration
Alberta, Calgary	not stated	not stated	minimum of 5 sessions
Alberta, Edmonton	38 per cycle	2.7 psychologists, .5 psychiatrist, undisclosed number of psychiatric nurses	6 months to 1 year
B.C., Abbotsford	30 per cycle	1 psychiatrist, 1 head nurse, 8 psychiatric nurse-counsellors	18 to 24 months
B.C., Campbell R.	12 over 2 years	consultant psychiatrist, 2 social workers	3 months trial, 18 months treatment
B.C., Vancouver	not stated	not stated	48 weeks
Ontario, Brampton	not stated	not stated	6 months
Ontario, Kingston	121 from 1974-81	.5 psychiatrist, .5 psychologist, 3 psychiatric nurses, 4.5 behaviour therapists	4 months
Ontario, Ottawa	not stated	1.5 psychiatrists, 2.5 psychologists, .5 social worker, 1 research staff	not stated
Ontario, Penetanguishene	4 to 7 per cycle	.5 psychiatrist, 2 psychologists	80 to 145 hours therapy
Québec, Montréal	not stated	not stated	2 years (Pinel), 6 to 12 months (other)
Saskatchewan, Prince Albert	30	2 therapists (unspecified discipline)	not stated
Saskatchewan, Saskatoon	24	psychiatrists, psychologists, psychiatric nurses, social workers (unspecified number of each)	6 months

Table 3, continued

Province (City)	Treatment Intensity	Location	In/Outpatiency	Community Resources
Alberta, Calgary	not stated	hospital ward	outpatiency	is a community-based program
Alberta, Edmonton	not stated	secure hospital ward	inpatiency outpatient booster sessions available	community clinics; and outpatient services
B.C., Abbotsford	25 hours/week	forensic hospital	inpatiency	outpatient services
B.C., Campbell R.	2-3 hours/week	community centre	outpatiency	is a community-based program
B.C., Vancouver	not stated	hospital forensic services	outpatiency	outpatient services
Ontario, Brampton	not stated	hospital forensic ward	inpatiency	outpatient services
Ontario, Kingston	2 groups/week	prison treatment centre	inpatiency	none used
Ontario, Ottawa	program dependent	hospital forsensic ward	both	is a community-based service
Ontario, Penetanguishene	+15 hours/week	maximum security hospital	inpatiency	none used
Québec, Montréal	case dependent, average 5 hours/week	hospital forensic ward	inpatiency	except Pinel are community-based
Saskatchewan, Prince Albert	4 hours/week	prison group work area	inpatiency	not stated
Saskatchewan, Saskatoon	10-15 hours/week	forensic hospital	inpatiency	none used

Duration of treatment was variable, and does not appear to be dependent upon whether programs are for inpatients or outpatients. Importantly, many of the regimens offering behavioural arousal conditioning noted that they will keep an offender in therapy until deviant arousal is diminished. This of course means that duration is case-dependent. Fortunately, in delivering case-specific amounts of treatment, these programs avoid a problem indicated in the U.S. programs, wherein the same quantity of therapy was offered to all, thereby running the risk of undertreating the more sexually deviant participants. However, such a statement is speculative since limited evaluation and follow-up data were provided.

Location

In contrast to the American sex offender treatment programs, which were often carried out within the confines of a prison, most of the Canadian programs were offered on the forensic wards of hospitals (mental health or general) or on wards of specialized centres (eg., the RPC's). Exceptions were the Campbell River, B.C. and the Saskatchewan Penitentiary programs. It is interesting to note that even the majority of the outpatient-based treatments were offered through hospitals. It is likely that this situation occurs more as a result of funding and less as a result of therapeutic orientation (i.e., medical versus nonmedical models).

Community Resource Outlets

Eight centres noted the use of community services (Table 3). Unfortunately, in those cases where such services were noted, few details were provided. In most cases, it was simply stated that community resources were made use of during the transitional phase of treatment or during outpatiency. As was the case in the U.S., the parole boards and probation authorities had input in the coordination of such services in cases where they were provided after release.

Despite the lack of detail, several points are worthy of mention. First, one quarter of the programs are community-based at the outset. These provide outpatient as well as inpatient services to those referred and to program graduates. Second, the Alberta Hospital Edmonton maintains close contract with local youth development centres and even offers a program for adolescent sexual deviates. Third, the Abbotsford program (RPC Pacific) was the sole program to explicitly mention the inclusion of a "separation stage", whereby participants are trained to make use of personal resources once outside the RPC. However, to be fair, it should also be noted that since the majority of the programs release inmates from their centre back into the prison population, the question of community services is somewhat moot.

Campbell River, B.C. required offender participation in family-oriented sexual abuse discussion groups, as was the case in Deleware, Maryland, North Dakota, Oklahoma and Vermont. However, some of the more innovative approaches, such as client participation in community meetings to increase public knowledge concerning sex offenders (Connecticut), and a 24-hour crisis "hotline" for outpatients and program graduates (Minnesota), were not used in Canada.

Theretical Orientation and Therapeutic Services Offered

The therapeutic orientations of the different programs, as described by their administrators, are presented in Table 4. They include behavioural, psychodynamic, therapeutic community, and humanistic approaches. In spite of this apparent variability, nine of the twelve programs offered behaviourally-oriented services.

The majority of programs appeared to be based upon the "sexual deviancy" (Freund 1963; Quisey, 1977) and "social competence" (Marshall, Christie, & Lanthier, 1977) models of disorder and treatment. In this approach, etiological factors behind sex offenses are seen as an interaction of learned deviant arousal patterns (psychophysiological), and learned maladaptive heterosocial skills and attitudes. In this explicit behavioural formulation, not only are causative factors indicated, but the implications for treatment are rather direct. In many of the

U.S. programs, paraphilias were also considered to be learned behaviours, yet the treatment delivered often did not reflect the stated behavioural orientation. Instead, the services offered were predominantly group counselling.

It is noted that the Abbotsford, B.C. (RPC, Pacific) program is unique among resident programs in Canada. Specifically, it is an intensive group psychotherapy regimen as opposed to a behavioural program. This is owing to the fact that it is modelled after a nearby program at Fort Steilacoom, Washington. As such, it is the only Canadian program that is directly modelled after an American plan.

In comparison to treatment approaches used in American programs, a number of specific differences were evident. The main difference centred around there being predominantly behaviourally-oriented services in Canada, whereas group counselling was the modal treatment techinque in the U.S. Moreover, 75% of the Canadian programs performed arousal conditioning using aversive methods (shock, noxious odors), whereas this procedure is rarely used in the U.S. programs surveyed. Given that Canada is a relatively less litigious society, this finding is not surprising. However, in some facilities, such as the Alberta Hospital in Edmonton, hospital by-laws forbid the use of aversive procedures. In these cases, nonaversive arousal conditioning methods are employed, such as covert sensitization. It is stressed that in those locations

Table 4

Province (City)	Therapeutic Services Offered
Alberta, Calgary	arousal conditioning (biofeedback, nonaversive), social skills training with homework assignments.
Alberta, Edmonton	encounter group & individual counselling, arousal conditioning (nonaversive) and chemotherapy (as required), social skills training, prevocational training, recreation.
B.C., Abbotsford	insight-oriented group therapy, arousal conditioning (aversive and non, limited use), self-assertive training, sex education, heterosexual skills training, work program.
B.C., Campbell R.	confrontive group therapy, impulse control (behavioural, nonaversive), family therapy.
B.C., Vancouver	arousal conditioning and impulse control (behavioural, nonaversive), life skills, social skills training, sex education, problem solving skills training.
Ontario, Brampton	arousal conditioning (aversive and non), confrontive group psychotherapy, 'attitude reshaping', empathy training, communication skills training.
Ontario, Kingston	arousal conditioning (aversive and non), chemotherapy, group psychotherapy, sex education, heterosexual skills training, assertive and relaxation skills training.
Ontario, Ottawa	arousal conditioning (aversive and non), chemotherapy, individual, family and group therapy, social skills and assertive training.
Ontario, Penetanguishene	arousal conditioning (aversive and non), self-management techniques, sex education, heterosocial skills training.
Québec, Montréal	arousal conditioning (aversive and non), insight-oriented group psychotherapy, social skills and empathy training, sex education, institutional work duties.
Saskatchewan, Prince Albert	insight-oriented group therapy, stress management, assertive training, sex education.
Saskatchewan, Saskatoon	arousal conditioning (aversive and non), group & individual psychotherapy, chemotherapy (limited), heterosocial skills training, sex-education, stress-management, drug/alcohol group.

Table 4, continued

Province (City)	Orientation	Evaluation and Follow-up
Alberta, Calgary	behavioural	arousal change monitoring (plethysmography), monthly follow-up by phone (no data provided).
Alberta, Edmonton	behavioural, therapeutic community	pre- and posttreatment psychometrics and plethysmography, once weekly or once monthly postprogram sessions--depending on group--for 6 months (no data).
B.C., Abbotsford	self-help therapeutic community	arousal change monitoring (plethysmography), behavioural observations. RPC staff visits to offenders' home institutions. 33% attrition rate.
B.C., Campbell R.	humanistic	none
B.C., Vancouver	behavioural/cognitive	behavioural target change evaluations (no data provided.)
Ontario, Brampton	behavioural, therapeutic community	pre- and posttreatment plethysmography. Outcome on 2 cases reported.
Ontario, Kingston	behavioural, educational	81/121 released to community. 15/81 recidivate (6 for sex crimes, 9 for parole violations).
Ontario, Ottawa	behavioural, educational	none
Ontario, Penetanguishene	behavioural, educational	pre- and posttreatment plethysmography, blind ratings of heterosocial skills, scores on sex education evaluation. After 29 months, recidivism offense pattern related to pretreatment measures.
Québec, Montréal	behavioural with dash of psychodynamics	arousal change monitoring (plethysmography), recidivism (major outcome evaluation variable), unsystematic phone calling of participants 3 months after graduation (no data provided.)
Saskatchewan, Prince Albert	psychodynamic	subjective evaluations by therapist (no data provided.)
Sask., Saskatoon	behavioural & eclectic	pre- and posttreatment psychometric battery and plethysmography (no data).

using of aversive methods, it is always performed with the informed consent of the client, and in all cases inmates not only choose their own shock frequency, but are given a sample shock prior to signing the consent so that the consent is truly an informed one.

In addition to arousal conditioning therapy, which is a common treatment for the "deviant sexual arousal" component of the popular behavioural model, group psychotherapy is routinely offered in most programs. Individual counselling is also available at several facilities upon request.

In order to train the participant sex offenders to be "socially competent", most programs include some form of sociosexual education (which incorporates sex education and hetersocial skills training), life skills training (which will include assertiveness training and some stress and time management instruction), vocational training, and drug/alcohol treatment where applicable. In resident programs, traditional in-house recreational and work activities are also provided.

Lastly, since most programs are conducted within hospital settings, it is not unusual to find that antiandrogen treatment is available as required.

Evaluation and Follow-up

Like their American counterparts, the Canadian programs were weakest in the area of evaluation and follow-up. Since many programs were relatively new or in a start-up phase, evaluation data generally were not available. Moreover, many of the programs which had been in existence simply described their evaluation procedure, or provided inadequate data. In none of the documentation provided was there any evidence of using control groups to assess program effectiveness. However, most of the documentation made note of the ethical and methodological difficulties inherent in the use of such methodological controls.

On the other hand, it is reassuring to note that 10 of the 12 treatment schemes have evaluation and follow-up mechanisms. The typical process measure to determine dimunition of deviant arousal is postreatment plethysmographic responses to sexual stimuli. To evaluate the acquisition of heterosocial skills and adaptive attitudes, posttreatment ratings (sometimes blind) are made. Postreatment psychometric batteries were mentioned in only three facilities (Alberta Hospital - Edmonton, University of British Columbia Medical Centre, Regional Psychiatric Centre - Saskatoon).

In terms of outcome measures, in Montréal, Penetanguishene and Kingston, the major variable is recidivism. In Edmonton, the maintenance of nondeviant arousal (as determined by plethysmography at intervals following program graduation) is used as the outcome variable.

Considering the follow-up of program graduates, the Calgary General Hospital, Alberta Hospital - Edmonton, the RPC (Pacific), and the Montréal programs all attempt to maintain contact for at least some period of time after program graduation. Other programs, such as that in Kingston, rely mainly on recidivism statistics for follow-up information.

In short, even though evaluation components may be in place in most programs, evaluation data are scarce. As such there is no indication as to which program components might be most important or even essential to program success. Nonexperimental or "descriptive" follow-up reports of sexual offenders (eg Kingston) imply a high rate of post-incarceration success. Nonetheless, as disclosed in the American survey, it has yet to be determined whether the expense of sex offender treatment programs is justified by a reduction in sexual reoffense rates. From the documentation provided, it is apparent that several very good evaluation studies are being conducted in conjunction with existing programs. However results are still pending.

Summary and Conclusion

In summary, it appears that the behavioural research tradition as it pertains to studies of deviant sexual arousal and its modification has directly affected the mode of treatment in Canada. Three quarters of the programs surveyed expressed a strong behavioural orientation. This was illustrated by the frequent use of psychophysiological assessment techniques and the popularity of conditioning, impulse control and self-management approaches to therapy. Nonetheless, a wide range of treatment approaches was in evidence. For example, humanistic approaches and self-help therapeutic communities were also cited.

Concerning clients and staff, programs tend to be oriented towards pedophiles and rapists, facilities are adequately staffed, and consist of a multidisciplinary team of professionals.Virtually all treatment is voluntary. Programs are quite varied in intensity from (two to twenty five hours per week), and duration (from five sessions to two years). Most program are provided on a inpatient format although post-release attempts are made to follow-up the therapeutic gains made by the client during treatment participation. Although understanding under the circumstances, the lack of reliable outcome data is disheartening.

Finally, on is left with a distinct feeling that the volume of clients that can be accommodated by these programs on an annual basis is far less than the need for service. This point was made by a parliamentary sub-committee investigating the Correctional Service of Canada in 1977 (McGuigan, 1977). At that time, only 8% of the known federally incarcerated sexual offenders were participating in an active treatment program. Although this situation has been partially ameliorated in prisons with the creation of new programs, further advances need to be made. With respect to the need for services in the community, one can only speculate, but the deficit in service provision appears to be even greater.

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Appendix A

STATE PROGRAMS FOR SEX OFFENDERS

State_____ Year of Documentation_____

When Implemented_____ Year of Overhaul(s)_____

Coordinating Agencies_____

Type of Therapeutic Services Offered: 1) Assessment/Treatment_____

2) Disciplinary Bent_____

Ancillary Programs (?) and Type_____

_____

Community Resource Outlets_____

Restitution Programs (?)_____

Number of Convicts Handled/Year_____

% of Convicts as Outpatients_____ as Inpatients_____

Potential Avenues of Placement within Institution (Type & Number)_____

_____

Predominant Characteristics of Offenders Receiving Special Placements

_____

_____

_____

_____

_____

_____

How Assessed_____

_____

Who Has Final Say in Placements_____

Staff: Type and Number (Psychiatric only)_____

_____

Amount of Treatment (Hours per Week)_____

Locations (Prison, Hospital, etc.)_____

Services Available for Voluntary Admissions (Y/N and What)_____

_____

Evaluation (Y/N, Empirical or Subjective)_____

High Level Custodial or Rehabilitative_____

Completion and Drop-Out Rate_____

Outcome (re: Recidivism, Subjective Impression of Participants)_____

_____

Follow-up (Y/N and same information as per outcome)_____

_____